Systems Change Review Orientation

Milwaukee Partnership Council

Critical Incident Subcommittee

11/23/20

Act 78

- Signed into law 11/13/2009; effective 2/1/2010
- Public disclosure of child deaths or near deaths as a result of suspected maltreatment, or experienced sexual abuse or death by suicide while in out-of-home care
- Subsequent statutory changes: §48.981(7)(cr)
  - LCWA must notify DCF of reports of death or near death
  - DCF determines if the incident meets requirements for public disclosure, and if so, what type of follow up is necessary (summary or practice)
  - DCF notifies the public of summary findings 90 days later; in some cases an additional summary 6 months later will also be published
  - Determinations about the type of review and additional notification is based on the local child welfare agency's recent and relevant history with the family prior to the critical incident.

History of Case Reviews

(2009–Q2 2015): Record & On-site Reviews

- BPM conducted a record review and determined who to interview, if needed
- Period under review (PUR) determined by BPM on a case-by-case basis
- Findings identified in Final Report to agency
- Monitoring of ongoing Implementation Plans

(Q3 2015–Q2 2018): Practice Reviews

- BPM conducted a record review and determined who to interview, if needed
- Period under review (PUR) determined by BPM on a case-by-case basis
- Technical errors, findings and recommendations identified in Final Report to agency
- Monitoring of ongoing Implementation Plans

(Q2 2018–present): Systems Change Reviews

- Local child welfare agency experience:
  - Experience of a critical incident is traumatic for a workforce dedicated to facilitating protection and services for the most vulnerable children
  - Agency leadership desired acknowledgement of the affect on the workforce
  - Process for examining these types of cases left agencies thinking their practice was misunderstood because errors in practice were explained by lack of compliance
  - Cases were contextualized within the local child welfare agency and not the community
  - Inefficient- took too long to move from incident to final report production

Systems Change Review (SCR)

- Applied to cases that qualify for a Practice Review under Act 78
- Utilizes principles from Human Factors and System Safety Science to support DCF to learn from critical incidents and promote system-wide improvement efforts
- Framework is trauma-informed and supports the complex and important work with families served by the child welfare workforce
- SCR includes collaboration between the local child welfare agency, tribes, community stakeholders, the DCF and other relevant parties

Safety Science: Contrasting Views of Safety

Old View of Safety	New View of Safety
Workers and their errors are the cause of adverse events	Adverse outcomes emerge from pressures deeper within and outside of our organizations
Learning ends when we discover noncompliance or departure from best practice	Learning begins when noncompliance and departure from best practice is identified
Safety is created through quick fixes that target frontline workers (i.e. policy, compliance, retraining, reprimand)	Safety is created through enhancing the environment in which people work (i.e. removing barriers, adding supports, building better processes)
Decisions made are the outcome of internal strengths/weakness of the individual that makes them	Decisions are complex and cannot be isolated internally to the individual making them. Decisions are outcomes from the complex interplay between people and the environment around them – decision are made because they are locally rational to the person making them

Safety Science:
Six Transitions to a New View of Safety

Transition 1: Blame to Accountability

Understanding how to learn and improve as an organization.

- To adequately learn, must transition from blame to accountability
- Blame ≠ Accountability
  - Inverse relationship
    - More we blame, less we hold ourselves accountable
    - Complex system, contribute bad outcome to a single person or event (what are we not paying attention to)
- Blame is backward looking
  - Same pattern when critical incident occurs
  - Decreases engagement
  - Used for utility and control
  - Simple problem = simple solution
- Accountability is forward looking
  - Supports thinking and learning
  - Makes us better, rather than “feeling” better

Transition 2: Applying Quick Fixes to Understand Underlying Features

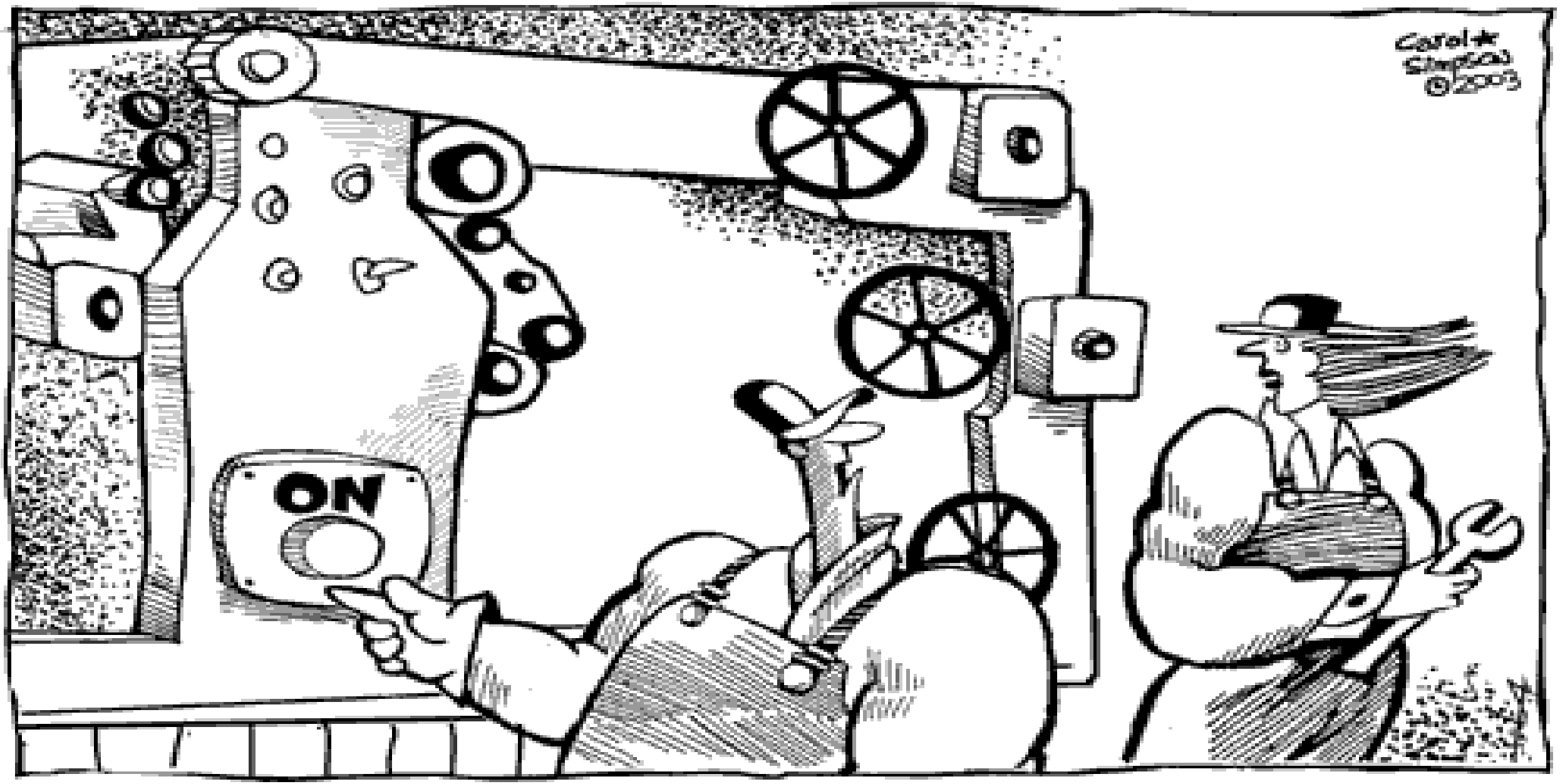
Making meaningful change in order to address the real problem(s).

- To make meaningful improvements, must start addressing the things that matter
  - When a critical incident happens, we do the same things
    - New policy, memo, tools, checklists
    - New trainings/retraining
    - More document
    - Reprimand, write up, fire
  - As we add things, it makes things harder and more complex (does not fix)
    - Workers feel judged, not supported
- Cannot just address the person, must address the context/environment in which work is taking place

Transition 3: Fallible Humans in Perfect Systems to Fallible Humans in Imperfect Systems

Learning the role of the system on organizational outcomes

- Often only look at people as the problem, this assumes that the system their working in is perfect
  - In order to reduce errors, we'd have to slow down
  - In order to eliminate human errors, then we need to eliminate humans
- Must move away from seeing CW system as perfect and whenever there is a problem we look to the humans
- Reality is we have imperfect people working in imperfect system



"This machine is perfectly safe...
As long as you never press this button."

Imperfect CW Systems: Competing Contingencies

- Safety is not always number one
  - Ex: Teenage drivers
- A lot of competing contingencies in child welfare
  - It sounds good to say that safety is first in child welfare, but we shift priorities based on the need
  - Ex: Keeping sibling groups together; focusing on placement stability

Transition 4: First Stories to Second Stories

- First stories
  - Typical, superficial way to explain when things go wrong
  - Were most learning ends
  - WYLFIWYF principles
  - Should never exist in isolation
- Second stories
  - Understanding the why behind behaviors
    - Highlights time pressures, incomplete information, service unavailability, stress
  - Rich information that can be used to learn and improve
  - Does not eliminate first story, provides context

Diving beneath surface level descriptions of events and understanding the true sources of failure and success.

Transition 5: Employees are Not a Problem to Control, Employees are a Solution to Harness

Making use of the most powerful resources an organization has – its people.

- If we want to understand unfavorable outcomes/decisions, we need to get in the cockpit with them
- Our workforce is not the problem to control
  - Instead, we need to give credit to the people that deserve it
- Things go right because we have workers
  - CW system needs workers who have autonomy to think critically and make decisions
- Historically put barriers around people because we think they are the problem and take people away from the work that they want to do
  - Policies, procedures, rules

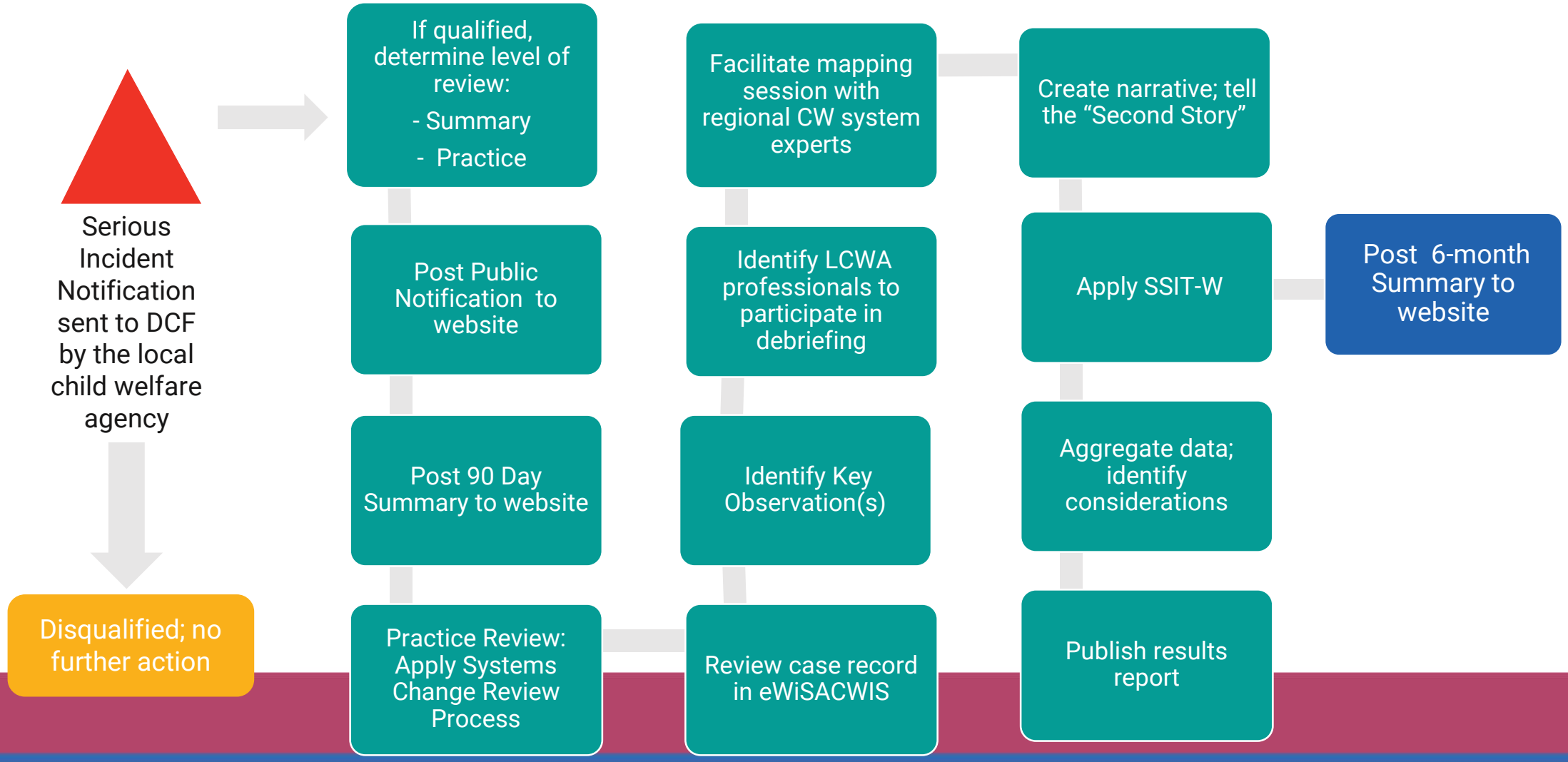
Transition 6: Simple to Systemic Accident Models

- If we want to learn and improve, then the model of learning has to be compatible with the system that we're studying
  - Learning process must be able to pick up on the complexities of the system and how it actually functions
- Move away from compliance and checklists as a way to review cases

Using accident models that are compatible with the complex world we work in.

Wisconsin Critical Incident Review Process

Systems Change Review Process Flow



SCR Process

- BOS implemented in November 2016; Milwaukee implemented in June 2018
- Cases qualify based on frequency or recency of relevant contact with CPS
- DCF notifies agency directors when a case qualifies for a SCR
- Qualified cases are mapped two quarters later

Local Agency & CPS Professional Impact

- Cases do not qualify for a SCR based on the level of egregiousness or seriousness of the critical incident
- May be a significant time delay from the time a case qualifies to the time the case is reviewed and mapped

Case Record Review

- Case record review completed by Wisconsin Reviewer
  - PUR: 1 year prior to the critical incident
  - Not reviewing critical incident
  - Includes all relevant case work from any county/agency (Access, IA, Ongoing, Licensing, etc…)
  - Concludes with identification of “Key Observations”
- Wisconsin Reviewers
  - Contracted CPS professionals with local child welfare expertise
  - Selected for leadership, depth and breadth of knowledge and expertise regarding child welfare policy and practice, excellence in engagement and facilitation, critical and systems thinking

Local Agency & CPS Professional Impact

- Record review includes any case work completed during the PUR (prior to the incident)
  - May include staff who had the case several months before
- Record review can include review of other cases relevant to the case where the critical incident occurred
  - Companion CPS cases
  - Licensing cases
  - Relevant work and/or cases from other agencies and/or counties

Key Observations

- Key Observations are case facts that provide opportunities for studying and further learning
  - Deviations from policy or expected practice
  - Areas of normal case practice and critical decision points that we want to learn more about
- Key Observations are not:
  - Related or causal to the critical incident
  - Opinions or value judgements about case work or decisions
  - Placing blame on the individual or agency
- Key Observations identified collaboratively between the Wisconsin Reviewer and SCR Lead

Key Observation Examples:

- *Initial F2F contact did not occur within the assigned response time*
- *F2F contact did not occur with all household members*
- *During the course of the IA, new information was received, but was not assessed*

Human Factors Debriefing (HFD)

- One-on-one session with professionals aimed at gathering additional information that cannot be found in the case record
  - Learning about the “why” behind decisions or actions (non-judgmental)
  - Assumption that behavior is rational – if it makes sense to one person, it will make sense to someone else
- Goal: Learn how decisions are made in context:
  - How profess are focusing and directing their attention
  - How workers gain, activate and apply knowledge that guide decisions and actions
  - What workers are trying to pursue or accomplish when making decisions or taking actions
- CPS professionals identified to participate based on the Key Observation(s)
- Conducted individually with by Wisconsin Reviewer
- Characteristics
  - Voluntary
  - Confidential
  - Supportive
  - Safe

Human Factors Debriefing Expectations

- Safe place for CPS professionals
  - Explanation of the SCR process
  - Explanation regarding the reason for the HFD
  - Allow the professionals to account their story and share their experience
  - Open-ended, intentional questions

- *Tell me about any barriers you faced*
- *Tell me about how you used standards to guide your practice on this case*
- *Tell me about how your past experiences may have influenced your decision-making*
- *Tell me about your decision-making process*
- *How did you prioritize tasks?*
- *What pressures where placed on you? Where were these pressures coming from?*

Human Factors Debriefing

Local Agency & CPS Professional Impact

- Contacted to participate in HFD 2-6 weeks before the mapping session; will vary based on the Wisconsin Reviewer
- Those identified to participant will receive an email and/or phone call from the Wisconsin Reviewer
- HFD generally scheduled for 1-1.5 hours; can occur at the agency or in the community
  - Wisconsin Reviewers are flexible and will work around your schedule
- No requirement to review the case record prior to participating in the HFD
- No repercussions for not participating in HFD

Systems Mapping

- Facilitated by the Wisconsin Reviewer
- Explores identified Key Observations and their influences at different levels of the system
  - Local/worker
  - County
  - State DCF
  - External
  - Government/Legislative

Systems Mapping

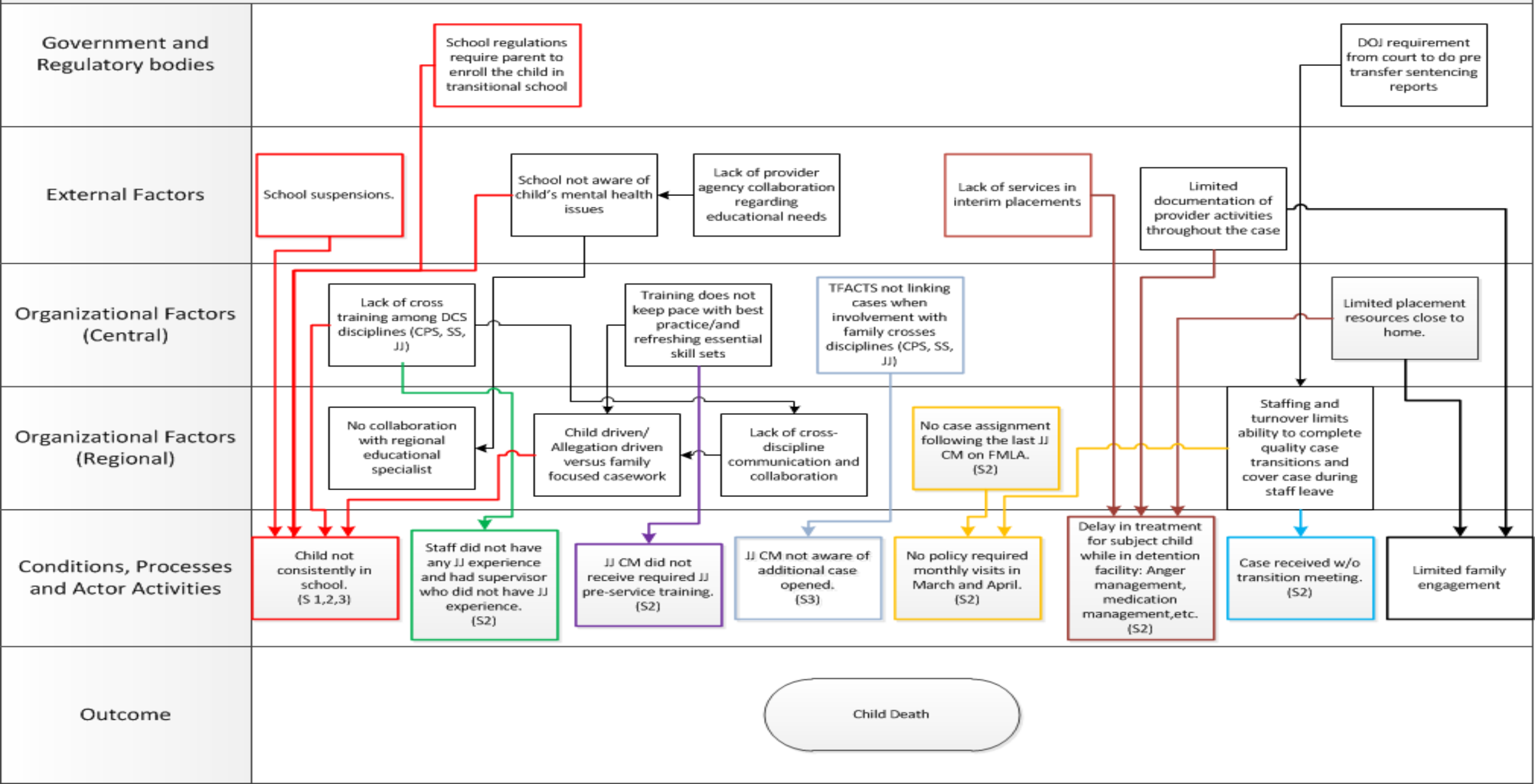
- Regional Mapping Teams
- Standing Mapping Participants:
  - Child welfare frontline staff
  - Child welfare supervisors
  - Child welfare directors/managers
  - Bureau of Regional Operations (BRO) staff
  - DCF Policy staff
- Ad hoc members may be identified to join depending on case factors

Local Agency & CPS Professional Impact

- Mapping team never includes the case worker or supervisor involved in the case
- Have representation from DMCPS and each contract agency

Safety Systems Map- Child Death/Near Death

Case No.: W D 051813 SS 092613



Narrative – Second Story

- Written by the Wisconsin Reviewer
- Derived from the Human Factor Factors Debriefing and Systems Mapping process
- Purpose of the narrative is to tell the second story
  - Provides contextual information to understand decision-making related to the Key Observation(s)

Scoring

- Safe Systems Improvement Tool – Wisconsin (SSIT-W)
  - Communimetric tool and improvement strategy
- Scores reflect whether an item was present and relevant in a case and supported by evidence
- Exemplars are used to explain scores of 2 or 3 to maintain integrity and provide detail of how the category manifested in a particular case
- Ratings translate to action levels designed to support quality improvement

Safety Action Workgroup (SAW)

- Ad Hoc workgroup of the CW CQI Advisory Committee
  - Focus on assessing aggregate information gathered and compiled from the SCR process
  - Identifying readily-actionable practice and program improvement opportunities to be considered by the CW CQI Advisory Committee
- Membership
- Reviewed aggregate SCR data (2017-2019), analyzed SCR data themes, identified KO themes for local- and systems-level improvements, brainstorming considerations

SAW Next Steps

- Developing considerations
  - Identifying ways to support child welfare workforce at local level
  - Identifying areas for systems improvement at state level
- Presenting information to the CW CQI Advisory Committee

More Information Available

- DCF has produced seven short, informative webinars on the Systems Change Review process.
  - They can be accessed on the DCF website here: https://dcf.wisconsin.gov/cwportal/webinars

- 2018-2019 SCR Results Report available on DCF website
  - Includes data and highlights recurrent themes inclusive of all cases mapped in CY2018 and CY2019
  - https://dcf.wisconsin.gov/cwportal/access-ia/act78

Discussion & Questions

Thank You!

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